Draft revised Mental Health Act 1983 Code of Practice: comments on issues relevant to children and young people

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"The 11 MILLION children and young people in England have a voice"
Children's Commissioner for England, Professor Sir Albert Aynsley-Green

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Introduction

This paper has been prepared on behalf of the Royal College of Psychiatrists and 11 MILLION.

The paper is in three parts:

- Part A provides an overview of Chapter 39 of the Draft Revised Code of Practice ('the Draft Code').
- Part B provides specific comments on Chapter 39 of the Draft Code.
- Part C comments on issues relevant to children and young people that are considered elsewhere in the Draft Code.

Part A - Overview

The Draft Revised Mental Health Act 1983 Code of Practice ('the Draft Code') contains, as one would expect, significant changes to the current Code of Practice. (The last Mental Health Act Code of Practice was published in March 1999 and is referred to in this paper as 'the 1999 Code'.) Much of the new material is helpful, for example the development of the 'guiding principles' specifically relevant to children and young people. The use of case examples and flow charts provides some assistance in understanding the text in relation to determining the authority to treat a child or young person.

Our main criticism relates to the failure to provide a clear explanation of the law in some key areas; this undermines the utility of the flow charts and case examples.

As the Draft Code notes, the legal framework for the provision of care and treatment of children and young people with mental health problems is complex. The existing confusion and uncertainty in this area is likely to be exacerbated with the introduction of the Mental Capacity Act 2005 which has general application to all persons aged 16 or over. However, sections of the Draft Code are poorly drafted and confuse rather than clarify the law.

We have identified the following areas as requiring particular attention.

1. Over emphasis on court intervention

On various occasions practitioners are advised to seek a court declaration or decision (see, for example, paragraphs 39.30, 39.33, 39.36 and 39.38). This contrasts with the reference in the 1999 Code to two specific situations where the 'assistance of the court may be sought.' (See paragraph 31.13) It needs to be recognised that identifying areas of uncertainty where the intervention of the court may be required tends to make clinicians and other professionals defensive and uncertain. This can then affect the child or young person by delaying the delivery of care and treatment. While areas of uncertainty should be pointed out, some of the areas of uncertainty identified in the Draft Code could be resolved by providing clearer guidance on the existing law.

2. Unclear links between the Mental Capacity Act 2005 and the Mental Health Act 1983

The links between the Mental Capacity Act 2005 and the Mental Health Act 1983 are not explained as clearly as they could be. Also, the guidance contained in the Mental Capacity Act Code (published 2007) does not always match the guidance in the Draft Code.

For example, paragraph 12.14 of the Mental Capacity Act Code states that:

> ‘If a young person has capacity to agree to treatment, their decision to consent must be respected. Difficult issues can arise if a young person has legal and mental capacity and refuses consent – especially if a person with parental responsibility wishes to give consent on the young person’s behalf. The Family Division of the High Court can hear cases where there is disagreement.’

The Draft Code (paragraph 39.25) states:

> ‘…However, unlike adults, the refusal of a competent person aged 16 – 17 may in certain circumstances be over-ridden by either a person with parental responsibility or a court…’

In general we found the analysis of the application of the Mental Capacity Act 2005 to children and young people contained in the Mental Capacity Act Code to be clearer than the analysis in the Draft Code. We suggest that further work should be undertaken to ensure that the text in the Draft Code replicates the guidance in the Mental Capacity Act Code.

There also appears to be an imbalance in the Draft Code between the amount of information provided about the Mental Capacity Act 2005 compared with the Children Act 1989.

3. Zone of parental responsibility

Although the new concept of ‘the zone of parental responsibility’ is helpful, the scope and limitations of the concept are not always clear. In particular, defining the ‘extremity’ of the intervention or treatment is crucial but there is little guidance in the Draft Code on what might be regarded as ‘extreme’. Furthermore the important issue of whether the consent of a parent to their child being deprived of their liberty falls within the ‘zone’ is not addressed.

This section should also make clear that when considering whether it is appropriate to rely on the consent of a person with parental responsibility, that person’s capacity to consent to the treatment will also be relevant. It should provide guidance to mental health professionals on what steps should be taken in the event of the person with parental responsibility not being able to make the decision in question.

4. Confidentiality

In contrast to the 1999 Code which simply stated ‘children’s rights to confidentiality should be strictly observed’ (paragraph 31.21), the Draft Code (paragraph 39.55) states that ‘all children and young people have a right to confidentiality’. It then adds:

> ‘However, where a competent young person or child is refusing treatment for a life threatening condition, the duty of care would require confidentiality to be breached to the extent of informing those with parental responsibility who might then be able to provide the necessary consent to the treatment.’

This difference in emphasis reflects other government guidance (Confidentiality NHS Code of Practice Department of Health 2003,

Annex B paragraphs 9 and 10). While this statement concerning confidentiality and the refusal of treatment for a life threatening condition is legally accurate, it is limited to exceptional cases. However, as set out in the Draft Code, it appears to have more general application, which may cause confusion. Therefore this statement's application to children and young people with mental health problems needs to be contextualised and made more explicit.

5. Overriding the refusal of the competent child

We have particular concerns about the lack of clarity in relation to overriding the refusal of a Gillick competent child. The guidance on this area is not adequate and, if left unchanged, will lead to continuing confusion and uncertainty.

During the Mental Health Bill's passage through parliament it was suggested that, in order to avoid any uncertainty or confusion, an express statutory provision should be introduced stating that the competent refusal of a child cannot be overridden by a person with parental responsibility. (A similar provision has been introduced in relation to 16 and 17 year olds.) The government resisted this, initially taking the view that this was unnecessary because the law was clear (such a refusal could not be overridden), but subsequently revised this position by stating that the matter would be best dealt with in the Code.

The draft illustrative Code (the precursor to the Draft Code) dealt with the problem succinctly.

> 'To put it simply, their [competent children under 18] decisions to consent to treatment or to refuse treatment should not be over-ridden by a person with parental responsibility.' (Paragraph 31.42)

This sentence has been removed from the Draft Code. The section 'Child or Young Person with capacity refusing treatment' (paragraphs 39.34 – 39.36) in the Draft Code provides a confusing summary of the law. For example paragraph 39.36 states:

> 'For other cases [child or young person with capacity refusing treatment], so long as there is no post-Human Rights Act 1998 authority for this proposition, it would be prudent, to obtain a court declaration or decision if faced with a competent child or young person who is refusing to consent to treatment, to determine whether it is lawful to treat the patient on the basis of the consent of a person with parental responsibility or whether the Mental Health Act should be used instead.'

It is not clear what these 'other cases' might be. This paragraph could be interpreted as advising practitioners to seek a court declaration before relying on the Mental Health Act in circumstances where a competent child is refusing treatment for mental disorder.

PART B - Comments on Chapter 39 of the Draft Code

39.4 Suggest delete ‘as follows’ at end of last sentence.

39.9 First bullet point: the best interests of the child and young person should be ‘a primary consideration’ (see UN Convention on the Rights of the Child, article 3).

Second bullet point: suggest that this should make clear that the information provided should be age-appropriate.

Penultimate bullet point: the previous draft illustrative Code had the words ‘to protect them or others from significant harm’ after ‘necessary’. Suggest that these are reinserted.

The last bullet point, entitled ‘Determining the most appropriate form of care’, has been misplaced and should form a subheading for paragraphs 39.10 and 39.11.

39.10 This is the first mention of section 25. We suggest the inclusion of an explanation of what it covers: ‘section 25 provides statutory authority to restrict the liberty of a child.’

39.11 This needs clarification in the light of the amended definition of ‘mental disorder’. For example, a behaviourally disordered young person will fall within this definition. (See paragraph 3.3 of the Draft Code which lists conditions that could fall within this definition, including ‘behavioural and emotional disorders of children and adolescents’.) As section 25 has traditionally been used for this type of case, guidance should be available to both children’s services and mental health professionals as to which statutory regime is most appropriate to protect the interests of the child.

39.18 The reference to paragraph 39.28 is not correct.

39.19 Suggest rewording as follows:

> Where a child is not Gillick competent then it will usually be possible for a person with parental responsibility to consent to treatment on their behalf providing the treatment is in the child’s best interests. (The next sentence is poorly drafted and confusing. Furthermore, given that the same issues are covered in paragraphs 39.10 and 39.11 above and 39.24 below we suggest that the rest of the paragraph is not needed.)

39.23 Suggest rewording:

> The fact that a person with parental responsibility has agreed to the informal admission of a child should not lead professionals to assume that there has been consent to every aspect of the treatment plan. Consent should be sought for each aspect of the child's care and treatment as it arises. "Blanket" consent forms should not be used.

39.24 The use of the word ‘alternatively’ is confusing. Suggest rewording:

> If the decision is not within the parental zone of responsibility or the consent of a person with parental responsibility is not given, the Mental Health Act should be used so long as the child meets the conditions for admission set out in the Act. If the conditions are not met then it may be possible to treat a child informally on the basis of an order made by the court under its inherent jurisdiction, or by way of an order made under section 8 of the Children Act (specific issue orders).

39.25 This paragraph refers to the FLRA conferring a presumption of capacity. This may be misleading. We suggest the following rewording:

> Section 8 of the Family Law Reform Act 1969 provides that young people aged 16 and 17 are able to consent to ‘any surgical, medical or dental treatment’ and any ancillary procedures involved in that treatment, such as an anaesthetic. As for adults, consent will be valid only if it is given voluntarily, by an appropriately informed patient capable of consenting to the particular intervention.

We suggest that the last sentence commencing ‘However, unlike…’ is deleted and replaced with wording similar to paragraph 12.14 of the 2007 Mental Capacity Act Code. Reference will need to be made to the situation being different if section 131 Mental Health Act applies. If paragraph 39.26 is deleted, as we suggest, the explanation of section 131 would then follow in the next paragraph (currently 39.27).

39.26 Whist this paragraph is correct, we wonder whether it is necessary as it complicates an already complicated area that will have little application to the children and young people covered by this chapter.

39.27 Suggest deleting ‘itself’ from the first sentence. Suggest adding a further sentence at the end:

> If the young person does not consent then their refusal cannot be overridden by a person with parental responsibility and therefore consideration would need to be given to whether the conditions for compulsory admission under the Mental Health Act are met.

39.28 Suggest rewording the first sentence as follows:

> Under the Mental Capacity Act it should be assumed that adults aged 16 or over have full capacity to make decisions for themselves. In determining whether a young person aged 16 or 17 has the capacity to consent to the proposed intervention, the tests set out in section 3 of the Mental Capacity Act should be used.

Suggest that the rest of the paragraph and paragraph 39.29 is not needed; simply cross-refer to chapters 4 and 12 in the Mental Capacity Act Code.

39.30 Suggest that this paragraph is deleted as the information can be inserted in paragraph 39.33 below.

39.31 Suggest that the last sentence is deleted and replaced with the following paragraphs:

> It is, however, good practice to involve the young person's family in the decision-making process, unless the young person specifically does not want them to be involved.
>
> If a young person wishes to exclude his or her parents every effort should be made to fully understand the reasons for this and to explore what changes are necessary to allow the young person to share information with his or her family. If this does not happen the young person can "split" staff and parents in a manner which is unhelpful and may aggravate their distress.

39.33 This paragraph is likely to create much confusion. It is attempting to address too many issues. If it is thought necessary to refer to the question of whether the young person falls within the Mental Capacity Act's definition of incapacity or not, then either include the wording of 12.13 of the Mental Capacity Act Code here (which is much clearer) or cross refer to it. The distinction between incapacity under the Mental Capacity Act and incapacity that is outside this Act is very subtle and practitioners should be given some guidance on how to make such a distinction. None is provided here.

The point that the provisions under the Mental Capacity Act do not authorise the deprivation of a young person's liberty is a separate issue. Including it in this way here will only serve to add to the confusion.

This paragraph illustrates how the clarity of the flow charts is undermined by the text of the Draft Code. The flow charts make no reference to the Mental Capacity Act.

The final sentence, 'It would however be prudent to seek a declaration from the court…', is unhelpful because it implies that in **all** such cases the court should be asked to sanction treatment whereas, frequently, the legal authority to provide treatment will be clear.

39.34-39.36 These paragraphs need to be revised, particularly paragraph 39.36. If left unchanged, practitioners will be confused. Accordingly, we suggest that these paragraphs are deleted and the following rewording (including heading) is substituted:

> **Competent children or young persons with capacity refusing treatment**
>
> Section 131 means that where a young person of 16 or 17 with capacity is refusing to be admitted to, or kept in, hospital for treatment for mental disorder, they cannot be treated informally on the basis of the consent of a person with parental responsibility.

> Where the child is under 16 but is Gillick competent and is refusing treatment for mental disorder then that refusal should not be overridden by a person with parental responsibility and the Mental Health Act should be used if the conditions are met.
>
> Where a young person with capacity, or a Gillick competent child, refuses medical treatment for conditions other than mental disorder then it is possible that such a refusal could be over-ruled if it would in all probability lead to the death of that person or to severe permanent injury. In these situations it may be necessary to obtain a court declaration or decision to determine whether it is lawful to treat the patient on the basis of the consent of a person with parental responsibility.

39.37 Emergency treatment: this paragraph is confusing and needs to be reworded. It appears to be intended to cover children and young people of all ages, but it only refers to the 'patient' who is competent. Should there be reference to section 3(5) Children Act 1989 here? It would be helpful to provide details of the relevant court decisions referred to in this paragraph.

39.38 Suggest that the last sentence be deleted. If the treatment providers are confident that the treatment is in the child's interests, and they are treating with the consent of one person with parental responsibility, then advising that a court application is considered by the treatment providers is going to unnecessarily create anxiety, cause delay and increase costs. Should there be reference to section 2(7) Children Act 1989 here?

39.39 The reference to section 4 Children Act 1989 is unclear as most practitioners will not understand the scope of the section. Suggested rewording of the last sentence:

> These orders may include care orders, residence orders, contact orders, evidence of appointment as the child or young person's guardian, parental responsibility agreements or other orders under the Children Act.

The margin note could then refer to sections 4 and 4A of the Children Act 1989. Reference should also be made to section 27 Mental Health Act 1983 (children and young people in care and the Nearest Relative).

39.40 This paragraph simply does not make sense.

39.41 Suggest there should be some explanation of the concept of a child being 'looked after by a local authority', in particular that all 'looked after children' will either be subject to care orders or accommodated. If this distinction is made clear then the use of the term 'voluntarily accommodated' can be removed.

39.43 Suggest that the paragraph is reordered as follows:

> In assessing whether a particular decision falls within this parental zone of responsibility, two key questions must be answered:

- Firstly, is the decision one which a parent would be expected to make, having regard both to what is considered to be normal practice in our society and to any relevant human rights decisions made by the courts?

- Secondly, are there indications that the parent might not act in the best interests of the child?

The less confident a practitioner is as to whether s/he can answer both questions in the affirmative, the more likely it will be that the decision in question falls outside the zone.

39.44 - 39.45 The concept of the zone of parental responsibility is problematic. The examples given do not address key questions for practitioners. For example, deprivation of liberty is alluded to but no information on what might amount to the deprivation of liberty of a child is given. It would seem that the 'extremity' of the intervention or treatment is crucial, but there is little guidance here on what might be regarded as 'extreme'. Does the authorisation of ECT fall within this zone? The paragraph states that 'anything that goes beyond the kind of decisions parents routinely make will be more suspect'. Most of the decisions parents would be asked to make in relation to the care and treatment of their child's mental disorder will be anything but routine.

39.44 We suggest that another bullet point is added:

The susceptibility of young people to parental responsibility - some young people will accept that parents can make decisions on their behalf and can find this a relief in distressing situations. On the other hand, in the case of young people who have had little meaningful contact with their parents for some time it would not be reasonable to rely on parental consent.

39.46 Suggest that, under the heading 'Age-appropriate services', reference is made to section 131A

39.52 Suggest adding the following sentence:

The MHRT have established a specialist panel of tribunal members to deal with cases involving children and young people and therefore hospital managers and other professionals should ensure the MHRT is alerted to any such case.

39.54 Is the reference to 'See paragraphs 25.35 and Chapter 25…' correct?

The Mental Health Act 2007 introduces some significant changes to the provisions concerning the authorisation of ECT. However, these changes are not sufficiently explained in relation to children and young people. See comments to Chapter 25 below.

39.55 As this chapter is written with children and young people with complex mental health difficulties in mind, the reference to refusal of

treatment ‘for a life threatening condition’ needs to be clarified. It is arguable that the necessity to compulsorily admit a child or young person to hospital because of their refusal to comply with psychiatric treatment could constitute such a condition. Is it being suggested here that the duty of care requires a CAMHS specialist to inform the parents of the child or young person following any admission?

Examples and flow charts

The flow charts are helpful but can be overly simplistic when compared to the text of the draft Code, and in some cases are inconsistent with the text.

The case examples are also helpful but again tend to oversimplify matters. For example, why is deprivation of liberty not touched upon in any of the case studies? Furthermore, it is not clear from example C why it is not considered safe to rely on the parent’s consent. How can this be reconciled with paragraph 39.36 suggesting that it would be prudent to obtain a court order in such circumstances?

> Example C
>
> A 15 year old child. Assessed as being Gillick competent. The primary purpose of the intervention is to provide medical treatment for mental disorder. The child does not consent to treatment in hospital. The child's parents are keen for the child to be admitted to hospital and give their consent. However, it is not considered safe to rely on the parent's consent where a Gillick competent child is refusing. The child should be admitted to hospital for assessment (section 2) or for treatment (section 3) under the Mental Health Act if they meet the relevant criteria.

Part C - Issues relevant to children and young people elsewhere in the Draft Code

Chapter 2

2.11 Suggest that the following sentence is added after 'his particular case':

Information provided to children and young people should be appropriate to their age and understanding.

Chapter 3

As noted above, paragraph 3.3 lists the conditions that could fall within the amended definition of mental disorder and includes 'behavioural and emotional disorders of children and adolescents'. It would be helpful to include some guidance on this.

Chapter 4

4.60 – 4.62 These paragraphs refer to consultation with other people. There is no reference to the situation for children and young people and their parents. This is not dealt with in Chapter 39, save in relation to confidentiality (see above comments). Further guidance, specific to children and young people and their parents, is required.

Chapter 8

8.10 The patient can now apply to discharge the Nearest Relative. If there is a minimum age limit for the applicant this should be stated.

Chapter 25

25.23 The situation is different for children. We suggest that cross-reference is made to Chapter 39

25.43 There is insufficient guidance on ECT for children and young people. The Draft Code suggests that for a 16 or 17 year old, ECT could be provided in accordance with the Mental Capacity Act 2005. However there is no explanation of the situation for those under 16. Is it envisaged that a person with parental responsibility could authorise ECT? Or is this considered to be outside the zone of parental responsibility and, therefore, require a court to authorise such treatment?

Sub-sections 58A(4) and 58A(5) refer to patients who are capable or incapable of understanding the nature, purpose and likely effects of the treatment. Presumably the test for capacity will be as set out in the Mental Capacity Act 2005 for those over 16. If so, will this also apply to those under 16?

25.59 Cross reference is made here to Chapter 39, but there is very little information about Supervised Community Treatment (SCT) in Chapter 39. Suggest this paragraph is more explicit on what part of Chapter 39 the reader is being referred to. Alternatively, if the reader is being referred to Chapter 39 for general information only, add 'For

further information on the issues relating to the treatment and care of children and young people with mental disorder, see Chapter 39'.

Chapter 27

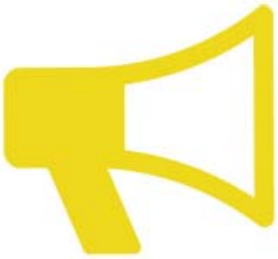
27.10 The meaning of this paragraph is unclear.

Chapter 28 (Supervised Community Treatment)

In our joint paper on Supervised Community Treatment ('Community Treatment Orders and Treatment in the Community', April 2007) we raised various concerns about CTOs, including the lack of involvement of those with parental responsibility. Paragraph 25.59 now provides some guidance on the role of the parent in relation to the treatment and care plan of a children and young people subject to CTOs.

However, the Draft Code provides insufficient guidance on how the SCT provisions will apply in practice, particularly in relation to the provision of treatment without the child or young person's consent.

For example, sections 64D and 64F of the Mental Health Act 2007 provide that non-emergency treatment can be given to community patients who lack capacity/competence irrespective of the patient's objection if it is not necessary to use force against the patient in order to give the treatment. We suggest that the Draft Code provides guidance on the scope of these sections, in particular what action would constitute 'force' and therefore not be permitted. It should also provide guidance on when emergency treatment in the community (where force may be used) would be appropriate in relation to children and young people – an example here would be useful.



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Children's Commissioner for England, Professor Sir Albert Aynsley-Green

11 MILLION, 1 London Bridge, London, SE1 9BG
Telephone: 0844 800 9113 Fax: 020 7357 8329
Email: info.request@11MILLION.org.uk
www.11MILLION.org.uk
CR009

The Royal College of Psychiatrists, 17 Belgrave Square, London, SW1X 8PG
www.rcpsych.ac.uk